LEA: ________________________

Physical Therapy Progress Notes

Student Name:	Medicaid #:	Month / Year:

Short Term Goals with acheivment

1. The student will
2. The student will
3. The student will
4. The student will
5. The student will
6. The student will
7. The student will

Treatment Log

Date	*Type of Contact	Short Term Goal Addressed (#)	Therapeutic Activity	Student Response to Treatment (must be measurable)	Initials
			☐Gait ☐Strengthening ☐Balance ☐Coordination ☐W/C Mgmt. ☐Motor Planning ☐Transfers ☐Ex. Program ☐Instruction of Staff / Caregiver ☐______________________		
			☐Gait ☐Strengthening ☐Balance ☐Coordination ☐W/C Mgmt. ☐Motor Planning ☐Transfers ☐Ex. Program ☐Instruction of Staff / Caregiver ☐______________________		
			☐Gait ☐Strengthening ☐Balance ☐Coordination ☐W/C Mgmt. ☐Motor Planning ☐Transfers ☐Ex. Program ☐Instruction of Staff / Caregiver ☐______________________		
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			☐Gait ☐Strengthening ☐Balance ☐Coordination ☐W/C Mgmt. ☐Motor Planning ☐Transfers ☐Ex. Program ☐Instruction of Staff / Caregiver ☐______________________		

*** Type of Contact:** **I = Individual** **G =Group** **SA = Student Absent** **TA = Therapist Absent**
U = Unavailable **C = Communication w/ parent or professional (not billable)**

______________________________ ______________________________ ________________
Therapist / Asst. Therapist Signature & Title | Printed Name and Title | Initials

______________________________ ______________________________ ________________
Supervising Therapist Signature & Title | Supervising Therapist Printed Name & Title | Initials

PT Long Form
KgB 8/00
Revised 03-01

Student Name:	Medicaid #:	Month / Year:

Date	*Type of Contact	Short Term Goal Addressed (#)	Therapeutic Activity	Student Response to Treatment (must be measurable)	Initials
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